NEW PATIENT REQUEST FORM

NAME: _____

Today's Date: _____

Date of Birth: _____

I have other family members needing care? ___Yes ___ No

If yes, please list names and dates of birth: _____

_____

Address: _____

Phone Number: _____

Referred By: _____

How long has it been since you've seen a dentist? _____

Previous Dentist's Name, Phone Number, City and State: _____

_____

What dental care do you think would suit you best:

- ☐ Comprehensive Care: optimal dental health and appearance
- ☐ Preventative Care: exams and cleanings
- ☐ Consultation to solve a specific problem
- ☐ Emergency Care: only as needed

Comments: _____

_____

I have dental insurance: ___ Yes ___ No If yes, please complete the next section.

Insurance company and phone number: _____

_____

Insurance policy holder's name and birthday: _____

_____

Insurance ID Number or Social Security Number: _____

Employer and Insurance Group Number: _____